Colorado's EHB Benchmark Plan Options

		Three Largest Small Group Plans			Largest HMO	State Employee Plans		Three Largest Federal Employee Plans			Mandates	
Option Reference:		A	B	C	D	E	F	G	H	I		
Carrier & Plan Name:		*Kaiser Ded/CO HMO 1200D*	*United Choice Plus Balanced 100*	*Anthem BCBS Lumenos HSA $5000/100% NGF*	*Kaiser Plan A230*	*Kaiser State Employee Plan*	*United State Employee Plan*	*BCBS Plan Standard [RI 71-005]*	*BCBS Plan Basic [RI 71-005]*	*GEHA Plan Standard [RI 71-006]*	*Colorado Mandate*	*Federal Mandate*
Enrollment:		*13,703*	*10,021*	*7,218*	*52,381*	*13,253*	*8,725*	*NA - #1*	*NA - #2*	*NA - #3*		
1. AMBULATORY PATIENT SERVICES												
a.	Primary care to treat illness/injury	√	√	√	√	√	√	√	√	√		FB
b.	Specialist visits	√	√	√	√	√	√	√	√			
c.	Outpatient surgery	√	√	√	√	√	√	√	√	√		
d.	Chiropractic (therapeutic, adjustive, manipulative)	NC	√ Limit to 20 visits per year	√ Limit 20 visits per year (combined with massage/ acupuncture)	NC	√ Limit 20 visits per year	√	√ Limit 12 visits/yr.	√ Limit 20 visits/yr.	√ Limit 12 visits/yr.		
e.	Chemotherapy services	√	√	√	√	√	√	√	√	√		
f.	Radiation therapy	√	√	√	√	√	√	√	√	√		
g.	Home health care	√	√ Limit 60 visits per year	√ Limit 100 visits per year	√	√	√ Limit 100 visits per year	√ Limit 25/yr., limit of 2 hr./visit	√ Limit 25/yr., limit of 2 hr./visit	√ Limit 50/yr.	CO	
h.	Access to clinical trials	NC	√ Some restrictions apply	√ Some restrictions apply	NC	NC	√ Some restrictions apply	√	√	√	CB	FB
i.	Genetic evaluation & counseling	Excluded, but available upon referral if inherited susceptibility for breast cancer or otherwise deemed medically necessary	Available only when reasonable to expect birth defects because of family history, parental age, or exposure to an agent	√ Some restrictions apply	May be covered if genetic testing is deemed medically necessary	May be covered if genetic testing is deemed medically necessary	√ Only covers fetal testing	√ Some restrictions apply	√ Some restrictions apply	NC		
j.	Outpatient diagnostic labs, x-ray, and pathology	√	√	√	√	√	√	√	√	√		
k.	Infertility treatment services	NC	NC	NC Only Diagnostic Services Provided, with limits Some restrictions apply	Only covers services for involuntary infertility and artificial insemination	√	Only diagnostic procedures covered	√	√	√ limit 3,000/yr.		
l.	Sterilization	√	√	√	√	√	√	√	√	√		

category continued on next page

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1. AMBULATORY PATIENT SERVICES, cont.											
m. Telemedical Services	Not specified	√	√ Some restrictions apply	Not Specified	Not specified	√	NC	NC	NC		
n. Dental Injury	NC	√	√ Some restrictions apply	NC	NC	√	√ only on emergencies and serious cavities for children 22 and under	√ only on emergencies and serious cavities for children 22 and under	√		
o. Cleft Palate and Cleft Lip Conditions	√	√	√	√	√	√	√	√	√	CB	
p. Oral Anti-Cancer Medication	√	√	√	√	√	√	√	√	√	CB	
q. Acupuncture	NC	NC	√ 20 visits per year (combined with massage/chiropractic); other restrictions	NC	NC	√	√ limit 24 visits	√	√ limit 20 visits/yr.		
r. TMJ services	Some services if medically necessary	NC	NC	Some services if medically necessary	Some services if medically necessary	NC	√	√	√		
s. Orthotics	√	NC	NC Some exceptions may apply	√	√	√	√	√	Not specified		
t. Vision Hardware	NC	NC	NC Some exceptions may apply	NC	NC	NC	√ Only covered for medical injury	√ Only covered for medical injury	√ Only covered for medical injury		

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	2. EMERGENCY SERVICES											
a.	Emergency room - Facility	√	√	√ Non-emergent care received in an ER not covered	√	√	√	√	√	√		FB
b.	Ambulance service	√	√	√	√	√	√	√	√	√		
c.	Urgent care centers/facilities (Provider-type, not a benefit)	√	√	√	√	√	√	√	√	√		
	3. HOSPITALIZATION											
a.	Inpatient medical and surgical care	√	√	√	√	√	√	√	√	√		FB
b.	Bariatric surgery	NC	NC	NC	√	√	√ Some restrictions apply.	√	√	√ only morbidly obese		
c.	Organ & tissue transplants	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs	√ Transplants limited to specified organs		
d.	Chemotherapy services	√	√	√	√	√	√	√	√	√		
e.	Radiation therapy	√	√	√	√	√	√	√	√	√		
f.	Anesthesia	√	√	√ Some restrictions apply	√	√	√	√	√	√		
g.	Breast reconstruction	√	√	√	√	√	√	√ following mastectomy	√ following mastectomy	√ following mastectomy		FB
h.	Hospice	√	√	√	√	√	√	√ Limit 1 episode every 30 days, where an episode is 7 consecutive days	√ Limit 1 episode every 30 days, where an episode is 7 consecutive days	√	CB	
i.	Dental Anesthesia	NC	NC	NC	NC	NC	NC	√	√	√		

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4. MATERNITY AND NEWBORN CARE												
a.	Pre- & postnatal care	√	√	√	√	√	√	√	√	√	CB	FB
b.	Delivery & inpatient maternity services	√	√	√	√	√	√	√	√	√	CB	FB
c.	Newborn child coverage	√	√	√	√	√	√	√	√	√	CB	FB
5. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT												
a.	Benefits for treating alcoholism & drug dependency	√	√ Limit 45 inpatient days per year (90 partial); limit 20 outpatient visits	√ Prior authorization for facility care required if not emergent.	√	√	√	√	√	√		FB
b.	Benefits for mental health services	√	√	√ Prior authorization for facility care required if not emergent.	√	√	√	√	√	√	CB	FB
c.	Biologically-based mental illnesses and disorders	√	√	√	√	√	√	√	√	√	CB	
d.	Outpatient hospital & physician	√	√ Limit 20 visits per year	√ Prior authorization for facility care required if not emergent.	√	√	√	√	√	√		
e.	Inpatient hospital	√	√ Limit 45 days per year (90 partial)	√ Prior authorization for facility care required if not emergent.	√	√	√	√	√	√		

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6. PRESCRIPTION DRUGS												
a.	Retail	√	NC	√	√	√	√	√	NC	√		
b.	Mail service (home delivery)	√	NC	√	√	√	√	√	NC	√		
c.	Contraceptives	√	√	√	√	√	√	√	√	√	CB	FB
d.	Home infusion therapy	√	NC	√	√	√	√ Covered as pharmaceutical products	√	√	√		

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7. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES												
a.	Physical, speech & occupational therapy	√ Limit 20 each therapy per year	√ Limit 20 each therapy per year	√ Limit 20 visits each therapy per year	√ Limit 20 each therapy per year	√ Limit 20 each therapy per year	√ Limit 20 each therapy per year	√ 75 visits/yr.	√ 50 visits/yr.	√ 60 visits/yr. for physical and occupational		
b.	Massage Therapy	NC	NC	√ Limit 20 visits per year (combined with chiropractic/acupuncture)	NC	NC	NC	NC	NC	Not mentioned		
c.	Cardiac rehabilitation	√	√ Limit 36 visits per year	√ Some restrictions apply	√	√	√	√	√	√		
d.	Pulmonary rehabilitation	√	√ Limit 36 visits per year	√	√	√	√	√	√	√		
e.	Durable medical equipment	√	√	√	√ Limited to home oxygen dispensing equipment, diabetes supplies, infant apnea equipment, prosthetics	√	√	√	√	√		FB
e.	Prosthetics - arm or leg	√	√	√	√	√	√	√	√	√	CB	FB
f.	Rehabilitative Services - outpatient	√	√	√ Some restrictions apply	√	√	√	√	√	√		
g.	Skilled nursing & rehab (inpatient)	√ Skilled nursing limit 100 days per year	√ Skilled nursing limit 60 days per year	√ Limit 30 rehab days; limit 100 skilled nursing days	√ Limit 100 days per year	√ Limit 100 days per year	√ Limit 30 days per year	√ up to 30 days but only with Medicare Part A	√ up to 30 days but only with Medicare Part A	√ 14 day limit, $700 limit per day		-
h.	Autism Spectrum Disorders	√	√	√	√	√	√	√	Not specified	√	CB	
i.	Physical, occupational, speech therapy for congenital defects up to age 5	√	√	√ Some restrictions apply	√	√	√ Covered for congenital defects from age 3 to 6	√	√	Not specified	CB	
8. LABORATORY SERVICES												
a.	Lab tests, x-ray services, & pathology	√	√	√	√	√	√	√	√	√		
b.	Imaging/diagnostics (e.g., MRI, CT scan, PET scan)	√	√	√	√	√	√	√	√	√		

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9. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT												
a.	Preventive care	√	√	√	√	√	√	√	√	√	CB	FB
b.	Immunizations	√	√ Not covered when required only for school, employment, activities, etc.	√ Not covered when required only for school, employment, activities, etc.	√	√ Limited to non-experimental and medically indicated	√	√	√	√	CB	FB
c.	Colorectal cancer screening	√	√	√	√	√	√	√	√	√	CB	FB
d.	Screening mammography	√ Annually for women over 40; earlier based upon risk	√	√ Annually regardless of age	√ Annually for women over 40; earlier based upon risk	√	√	√	√	√	CB	FB
e.	Vision Care (1 exam/24 months)	√ Hardware not covered	√ Limit 1 exam every 2 years	NC	√	√	√ Limit 1 exam per year	NC	NC	NC		
f.	Audiology/hearing tests	√ Adult hearing aids not covered	√ Limit one purchase every 3 years	Limited	√ Adult hearing aids not covered	√	√ Hearing aids supplied every 3 years	√ Non-routine, related to injury or illness	√ Non-routine, related to injury or illness	√ Non-routine, related to injury or illness		
g.	Nutritional counseling	√	NC - except for when nutritional education is required for a disease in which patient self-management is an important component of treatment.	√ Limit 4 visits per year	√	√	√	√	√	√		
h.	Smoking cessation program	√	√	√	√	√	√	√	√	√ Limit 2 attempts/yr	CB	
i.	Allergy testing & injections	√	√	√	√	√	√	√	√	√		
j.	Diabetes - medically necessary equip. & supplies; education	√	√	√	√	√	√	√	√	√	CB	
k.	Screening Pap tests	√	√	√		√	√	√	√	√	CB	
l.	Annual gynecological exam	√	√	√	√	√	√	√	√	√		
m.	Annual prostrate cancer screening	√	√	√	√	√	√	√	√	√	CB	FB
n.	Routine foot care	NC	NC	NC Some exceptions may apply.	NC	NC	NC	√	√	√ Only when under active treatment for metabolic or peripheral vascular disease		

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10. PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE											
a. Preventive care - physician svcs	√	√	√	√	√	√	√	√	√	CB	FB
b. Immunizations	√	√	√	√	√	√	√	√	√	CB	FB
c. 1 routine eye exam per year, to age 19	√	√	NC	√	√	√	√	√	√		
d. Routine hearing exams, to age 19	√	√	√	√	√	√	√	√	√		
e. Dental - diagnostic & preventive	NC	NC	NC	NC	NC	NC	√	√	√ Limit 2 per year		
f. Dental - basic	NC	NC	NC	NC	NC	NC	√	√	√		
g. Dental - major	NC	NC	NC	NC	NC	NC	√	√	√		
h. Hearing aids to age 18	√	√	√ Hearing aids supplied every five years	√ Hearing aids supplied every five years	√	√	√	√	√ Hearing aids supplied every 5 years	CB	
i. Children's early intervention services	√	√	√	√	√	√	NC	Not specified	Not specified	CB	
j. Children's dental anesthesia	√	√	√	√	√	√	Not specified	√	√	CB	

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MISCELLANEOUS												
a.	Phenylketonuria (PKU) Testing and Treatment	√	√	√	√	√	√	Not specified	Not specified	√	CB	
b.	Private Duty Nursing	√	Only under Home Health & Hospice	Only under Home Health & Hospice	√	√	NC	√	√	√		

NOTES

1. Abbreviation Key

√ : Indicates service is a covered benefit per plan documents.

NC: Not Covered. Indicates service is not a covered benefit per plan documents.

FB: Federal Mandate. Benefit required to be covered by federal law.

CB: Colorado Mandate. Benefit required to be covered by Colorado law.

CO: Colorado Mandated Offer. Benefit required to be offered as add-on to benefit package by Colorado law.

2. Compilation Process

Detailed enrollment and benefit information regarding each plan was submitted to DOI by each carrier. It was then summarized and compiled into this format. Where possible, we have included specified quantitative limits on benefits (eg, limited number of visits per year). However, table may not reflect all limitations on a particular benefit. Table does not include annual dollar limits on benefits, as these will be prohibited beginning in 2014.